



Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Pharmacy Fax 800-913-2229



Aetna Better Health of KS
PA Pharmacy Phone 855-221-5656
PA Pharmacy Fax 844-807-8453



Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929



UnitedHealthcare
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328

NON-PREFERRED PDL MEDICATION PRIOR AUTHORIZATION FORM
Complete form in its entirety and fax to the appropriate plan's PA department.
For questions, please call the pharmacy helpdesk specific to the member's plan.

MEMBER INFORMATION		
Name:	Medicaid ID:	
Date of Birth:	Gender:	
PRESCRIBER INFORMATION		
Name:	Medicaid ID:	
NPI:	Phone:	Fax:
Address:	City, State, Zip Code:	

Complete the following form to request approval of a non-preferred medication on the Kansas Medicaid Preferred Drug List (PDL).

Please note: Medications requiring PA may have to meet clinical **and** Non-Preferred PA criteria before the claim may be considered for payment

Please provide the required data for the specific drug being requested. Below is a list of links you may find helpful in determining the required information:

- Kansas PDL: <http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf>
- Non-Preferred, PA Required PDL criteria: http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf
- Clinical PA criteria: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- KS NDC lookup tool: <https://www.kmap-state-ks.us/Provider/PRICING/NDCSearch.asp>

Note: Any area not filled out will be considered not applicable to this PA & may affect the outcome of this request.

REQUESTED DRUG NAME & NDC	STRENGTH/FREQUENCY	QUANTITY	DAY SUPPLY
DIAGNOSIS		ICD-10 CODE	

NON-PREFERRED MEDICATION PRIOR AUTHORIZATION	
Check the appropriate box and provide the required information for consideration of approval of the requested non-preferred medication.	
<input type="checkbox"/> Does the medication requested also have clinical criteria? Search for the requested medication here: http://www.kdheks.gov/hcf/pharmacy/PA_Criteria/Clinical_PA_Table_of_Contents.pdf <input type="checkbox"/> YES <input type="checkbox"/> NO If <u>YES</u> : Please complete the Non-preferred sections in the appropriate Clinical PA criteria form. This form does not need to be completed.	
<input type="checkbox"/> If there is one preferred agent in the preferred category, has the patient experienced an inadequate response after a trial of the preferred agent at a maximum tolerated dose, or do they have a documented intolerance or contraindication to the preferred agent? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> INTOLERANCE/CONTRAINDICATION List previous medication trial and date(s) of trial: o Medication Name: _____ Date(s) of trial: _____ List medication intolerance or contraindication (if any): _____	

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long it is retained. In no event are you permitted to use or re-disclose such PHI.

UNIVERSAL NON-PREFERRED MEDICATION PRIOR AUTHORIZATION FORM

- ☐ If there are two or more agents in the preferred category, has the patient experienced an inadequate response after a trial of two or more of the preferred agents at their maximum tolerated dose, or do they have a documented intolerance or contraindication to two or more preferred agents?

☐ YES ☐ NO ☐ INTOLERANCE/CONTRAINDICATION

List previous medication trial and date(s) of trial:

- Medication Name: _____ Date(s) of trial: _____
 ○ Medication Name: _____ Date(s) of trial: _____

List medication intolerance or contraindication (if any):

- ☐ An appropriate formulation or indication is not available as a preferred drug. Please specify which formulation or indication is needed and information supporting the need.

- For formulation requests, please refer to the Non-Preferred PDL PA criteria to ensure specific requirements for oral, non-solid dosage forms, or nebulized formulations are met

http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf

RESCRIBER SIGNATURE

- ☐ I have completed all applicable boxes and attached any required documentation for review, in addition to signing and dating this form.

 Prescriber or authorized signature

 Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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